

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>172</u>	Intermediate (ICF)	<u>172</u>	<u>62,952</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>172</u>	TOTALS	<u>172</u>	<u>62,952</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>56,418</u>	<u>1</u>		<u>56,419</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>56,418</u>	<u>1</u>		<u>56,419</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.62%

D. How many bed-hold days during this year were paid by Public Aid?

NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 7/1/71

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **SACRED HEART HOME, INC.** # **0013334** Report Period Beginning: **01/01/00** Ending: **12/31/00**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	A. General Services											1
1	Dietary	185,331	26,086	32,867	244,284		244,284		244,284			1
2	Food Purchase		354,897		354,897	(36,468)	318,429	(0)	318,429			2
3	Housekeeping	160,130	31,564	11,674	203,368		203,368		203,368			3
4	Laundry	18,772	27,284		46,056		46,056		46,056			4
5	Heat and Other Utilities			74,914	74,914		74,914	1,088	76,002			5
6	Maintenance	215,929	66,356	69,958	352,243		352,243	(8,687)	343,556			6
7	Other (specify):*											7
8	TOTAL General Services	580,162	506,187	189,413	1,275,762	(36,468)	1,239,294	(7,599)	1,231,695			8
9	B. Health Care and Programs											
9	Medical Director			518	518		518		518			9
10	Nursing and Medical Records	440,808	23,496	380,782	845,086		845,086		845,086			10
10a	Therapy											10a
11	Activities	72,698	6,168	4,872	83,738		83,738		83,738			11
12	Social Services	109,562		87,013	196,575		196,575		196,575			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	623,068	29,664	473,185	1,125,917		1,125,917		1,125,917			16
17	C. General Administration											
17	Administrative	180,000		540,000	720,000		720,000	(376,237)	343,763			17
18	Directors Fees											18
19	Professional Services			26,744	26,744		26,744	4,547	31,291			19
20	Dues, Fees, Subscriptions & Promotions			4,700	4,700		4,700	640	5,340			20
21	Clerical & General Office Expenses		6,137	68,164	74,301		74,301	80,747	155,048			21
22	Employee Benefits & Payroll Taxes			134,209	134,209	36,468	170,677		170,677			22
23	Inservice Training & Education											23
24	Travel and Seminar			470	470		470		470			24
25	Other Admin. Staff Transportation			531	531		531	2,275	2,806			25
26	Insurance-Prop.Liab.Malpractice			85,881	85,881		85,881	1,050	86,931			26
27	Other (specify):*							33,195	33,195			27
28	TOTAL General Administration	180,000	6,137	860,699	1,046,836	36,468	1,083,304	(253,783)	829,521			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,383,230	541,988	1,523,297	3,448,515		3,448,515	(261,382)	3,187,133			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SACRED HEART HOME, INC.
0013334
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #

<table border="1"><tr><td>22</td></tr></table>	22	EMPLOYEE BENEFITS	<u>36,468</u>	
22				
<table border="1"><tr><td>2</td></tr></table>	2	FOOD		<u>36,468</u>
2				

To reclass cost of employee meals from raw food to employee benefits

<table border="1"><tr><td>33</td></tr></table>	33	REAL ESTATE TAX	<u> </u>	
33				
<table border="1"><tr><td>19</td></tr></table>	19	PROFESSIONAL FEES		<u> </u>
19				

To reclass cost of appealing real estate taxes

Facility Name & ID Number **SACRED HEART HOME, INC.** #0013334 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	Depreciation			46,351	46,351		46,351	5,013	51,364			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,101	2,101		2,101	27,417	29,518			32
33	Real Estate Taxes			349	349		349	5,559	5,908			33
34	Rent-Facility & Grounds			188,400	188,400		188,400	(188,400)				34
35	Rent-Equipment & Vehicles			11,357	11,357		11,357		11,357			35
36	Other (specify):*											36
37	TOTAL Ownership			248,558	248,558		248,558	(150,411)	98,147			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			18,655	18,655		18,655	(18,655)				41
42	Provider Participation Fee			110,122	110,122		110,122	(15,694)	94,428			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			128,777	128,777		128,777	(34,349)	94,428			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,383,230	541,988	1,900,632	3,825,850		3,825,850	(446,142)	3,379,708			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation	(2,377)	30	9
10	Interest and Other Investment Income			10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(0)	2	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties	(200)	21	18
19	Entertainment			19
20	Contributions	(100)	20	20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt			24
25	Fund Raising, Advertising and Promotional	(954)	20	25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,402)	21	26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule	(55,239)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,272)		\$ 30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	(383,870)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (383,870)	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (446,142)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

ID# 0013334
Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance	\$	6
2	Misc. Income	(342)	21
3	Vending Income	(18,655)	41
4	Personal Property Tax	(349)	33
5	Out-of-Period Bed Tax	(15,694)	42
6	Non-Care Depreciation	(115)	30
7	Taxes - Building Company	(3,000)	21
8	Capitalized R&M	(16,409)	6
9	Professional Fees - Bldg Co.	(675)	19
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(55,239)	90

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peter O'Brien	60%	see attached		see attached		
Daniel O'Brien	20%					
Mary O'Brien	20%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 188,400	Sacred Heart Building		\$	(188,400)	1
2	V	33 Real Estate Tax				1,051	1,051	2
3	V	19 Professional Fees				675	675	3
4	V	20 License & Fees				137	137	4
5	V	21 Taxes				3,000	3,000	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 188,400			\$ 4,863	\$ * (183,537)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	5 UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 1,088	\$ 1,088	15
16	V	6 REPAIRS AND MAINT.		MADO MGMT. LP		7,722	7,722	16
17	V	19 PROFESSIONAL FEES		MADO MGMT. LP		4,547	4,547	17
18	V	20 DUES AND SUBSCRIPTIONS		MADO MGMT. LP		1,557	1,557	18
19	V	21 CLERICAL AND GENERAL		MADO MGMT. LP		84,691	84,691	19
20	V	25 AUTO EXPENSE		MADO MGMT. LP		2,275	2,275	20
21	V	26 PROPERTY INSURANCE		MADO MGMT. LP		1,050	1,050	21
22	V	27 GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		14,764	14,764	22
23	V	30 DEPRECIATION		MADO MGMT. LP		7,505	7,505	23
24	V	32 INTEREST		MADO MGMT. LP		27,417	27,417	24
25	V	33 REAL ESTATE TAXES		MADO MGMT. LP		4,857	4,857	25
26	V	17 MANAGEMENT FEES	540,000	MADO MGMT. LP			(540,000)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 540,000			\$ 157,473	\$ * (382,527)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME, INC.

0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4		5 Cost to Related Organization		6	7	8 Difference:	
		Item		Amount		Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	\$		MADO MGMT. LP		100.00%	\$ 7,540	\$ 7,540	15
16	V	27	EMP. BEN.-D. O'BRIEN			MADO MGMT. LP			2,596	2,596	16
17	V										17
18	V	17	SALARY-P. O'BRIEN			MADO MGMT. LP			88,889	88,889	18
19	V	27	EMP. BEN.-P. O'BRIEN			MADO MGMT. LP			6,392	6,392	19
20	V										20
21	V	17	SALARY-C. STUMPF			MADO MGMT. LP			20,222	20,222	21
22	V	27	EMP. BEN.-C. STUMPF			MADO MGMT. LP			1,738	1,738	22
23	V										23
24	V										24
25	V										25
26	V										26
27	V										27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total			\$					\$ 127,377	\$ * 127,377	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	5 UTILITIES	\$	MADO MGMT. LP	100.00%	\$	\$	15
16	V	17 ADMINISTRATIVE SALARY		MADO MGMT. LP		47,112	47,112	16
17	V	21 CLERICAL SALARY		MADO MGMT. LP				17
18	V	27 GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		7,705	7,705	18
19	V	30 DEPRECIATION-WAREHOUSE		MADO MGMT. LP				19
20	V	33 REAL ESTATE TAXES		MADO MGMT. LP				20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 54,817	\$ * 54,817	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$ 28,874	Windy City Nursing	100.00%	\$ 28,874		15
16	V	10 Nursing	380,782	Windy City Nursing	100.00%	380,782		16
17	V	11 Activity	2,562	Windy City Nursing	100.00%	2,562		17
18	V	12 Social Services	85,543	Windy City Nursing	100.00%	85,543		18
19	V	21 Office	55,762	Windy City Nursing	100.00%	55,762		19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 553,523			\$ 553,523	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

SACRED HEART HOME, INC.

0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

the instructions for determining costs as specified on this form.									
1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

SACRED HEART HOME, INC.

0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SACRED HEART HOME, INC. # 0013334 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel O'Brien	Owner	Dir. of Operations	20.00	see attached	6	15.00	salary	\$ 180,000	17-1	1
2	Daniel O'Brien	Owner	Dir. of Operations	20.00	see attached	6	15.00	Alloc. Mado	7,540	17-7	2
3	Peter O'Brien	Owner	Administrative	60.00	see attached	16	26.67	Alloc. Mado	88,889	17-7	3
4	Charles Stumpf	Relative	Administrative		see attached	7	15.56	Alloc. Mado	20,222	17-7	4
5	James West	Relative	Clerical		see attached	9.3	23.25	Alloc. Mado	11,786	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 308,437		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

MADO MGMT. LP

Street Address

1541 N. WELLS ST.

City / State / Zip Code

CHICAGO, IL. 60610

Phone Number

(312) 787-9400

Fax Number

(312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	243,330	5	\$ 4,695	\$	56,419	\$ 1,088	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	243,330	5	33,305		56,419	7,722	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	243,330	5	19,610		56,419	4,547	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	243,330	5	6,715		56,419	1,557	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	243,330	5	365,265	298,189	56,419	84,691	5
6	25	AUTO EXPENSE	PATIENT DAYS	243,330	5	9,811		56,419	2,275	6
7	26	PROPERTY INSURANCE	PATIENT DAYS	243,330	5	4,530		56,419	1,050	7
8	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	243,330	5	63,675		56,419	14,764	8
9	30	DEPRECIATION	PATIENT DAYS	243,330	5	32,369		56,419	7,505	9
10	32	INTEREST	PATIENT DAYS	243,330	5	118,247		56,419	27,417	10
11	33	REAL ESTATE TAXES	PATIENT DAYS	243,330	5	20,949		56,419	4,857	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 679,171	\$ 298,189		\$ 157,473	25

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

MADO MGMT. LP

Street Address

1541 N. WELLS ST.

City / State / Zip Code

CHICAGO, IL. 60610

Phone Number

(312) 787-9400

Fax Number

(312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	30,158	30,158	6	7,540
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	10,385		6	2,596
3									3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	250,000	250,000	16	88,889
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	17,978		16	6,392
6									6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	130,000	130,000	7	20,222
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	11,175		7	1,738
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 449,696	\$ 410,158		\$ 127,377

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

MADO MGMT. LP

Street Address

1541 N. WELLS ST.

City / State / Zip Code

CHICAGO, IL. 60610

Phone Number

(312) 787-9400

Fax Number

(312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION	1	1,218				1
2	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION	5	303,237	303,237		47,112	2
3	21	CLERICAL SALARY	DIRECT ALLOCATION	3	80,490	80,490			3
4	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION	5	51,678			7,705	4
5	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION	1	1,082				5
6	33	REAL ESTATE TAXES	DIRECT ALLOCATION	1	1,865				6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 439,570	\$ 383,727		\$ 54,817	25

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Windy City Nursing

Street Address

1541 N. Wells Street

City / State / Zip Code

Chicago, IL 60610

Phone Number

(312) 787-9400

Fax Number

(312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$	\$		28,874	1
2	10	Nursing	Direct Allocation						380,782	2
3	11	Activity	Direct Allocation						2,562	3
4	12	Social Services	Direct Allocation						85,543	4
5	21	Office	Direct Allocation						55,762	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		553,523	25

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **SACRED HEART HOME, INC.**# **0013334**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	TIF Insurance		X	Insurance Financing								2,101	6	
7													7	
8													8	
9	TOTAL Facility Related						\$		\$			\$	2,101	9
	B. Non-Facility Related*													
10	Supplemental Schedule												10	
11													11	
12	Allocation from Mado Mgmt	X										27,417	12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$	27,417	14
15	TOTALS (line 9+line14)						\$		\$			\$	29,518	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number

SACRED HEART HOME, INC.

0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$		\$			\$	21

Facility Name & ID Number **SACRED HEART HOME, INC.**# **0013334**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	2,225	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	6,983	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,758	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	1,150	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	5,908	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	711	8		FOR OHF USE ONLY	
	1996	728	9			
	1997	696	10	13	FROM R. E. TAX STATEMENT FOR 1999	\$
	1998	1,082	11	14	PLUS APPEAL COST FROM LINE 5	\$
	1999	1,075	12	15	LESS REFUND FROM LINE 6	\$
				16	AMOUNT TO USE FOR RATE CALCULATION	\$

RE Tax on Line 2 includes \$4857 allocated from Mado Mgmt and \$1051 from Sacred Heart Bldg.

RE Accrual = 1999 tax + 7% (\$1075 x 107% = \$1150)

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SACRED HEART HOME, INC.

0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,940 B. General Construction Type: Exterior Frame Number of Stories 3

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			\$ 20,000	1
2					2
3	TOTALS			\$ 20,000	3

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1990		48,324	1,445	20	1,445		42,546	9
10	Various		1991		26,113	132	20	132		24,599	10
11	Various		1992		105,671	5,284	20	5,284		72,943	11
12	Various		1993		14,487	724	20	724		11,648	12
13	Various		1994		37,950	1,898	20	1,898		13,286	13
14	Various		1995		38,705	1,935	20	1,935		9,675	14
15	DOORS		1996		2,885	144	20	144		720	15
16	SECURITY SYSTEM		1996		582	29	20	29		145	16
17	ROOFING		1996		2,650	133	20	133		665	17
18	BOILER		1996		2,204	110	20	110		550	18
19	PLUMBING		1996		1,762	88	20	88		440	19
20	FIRE SYSTEM		1996		600	30	20	30		150	20
21	BOILER		1996		3,908	195	20	195		975	21
22	SUMP PUMP		1996		1,767	88	20	88		440	22
23	HEATER		1996		2,896	145	20	145		725	23
24	PLUMBING		1996		720	36	20	36		180	24
25	ROOF REPAIRS		1996		1,000	50	20	50		250	25
26	DOORS		1996		1,025	51	20	51		255	26
27	BOILER		1996		799	40	20	40		200	27
28	FLOORING		1996		2,046	185	20	185		925	28
29	PAINTING/DECORATING		1996		3,426	171	20	171		855	29
30	WATER HEATER		1996		2,840	142	20	142		710	30
31	SEWER/SIDEWALK REP		1996		1,532	77	20	77		385	31
32	ROOF REPAIRS		1996			155	20		(155)	620	32
33	FIRE PUMP		1996		676	34	20	34		170	33
34	ELEVATOR REPAIRS		1996		1,113	56	20	56		280	34
35	ELEVATOR IMP		1997		3,000	150	20	150		675	35
36	TOTAL (lines 4 thru 35)				\$ 308,681	\$ 13,527		\$ 13,372	\$ (155)	\$ 185,012	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	172		1971	1971	\$ 140,000	\$	20	\$		\$ 140,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1973	1973	9,000		20			9,000	9
10	Various		1974	1974	16,880		20			16,880	10
11	Various		1976	1976	4,234		20			4,234	11
12	Various		1977	1977	43,234		20			43,234	12
13	Various		1978	1978	50,867		20			50,867	13
14	Various		1979	1979	40,393		20			40,393	14
15	Various		1980	1980	4,392		20			4,392	15
16	Various		1981	1981	15,817		20			15,817	16
17	Various		1982	1982	15,180		20			15,180	17
18	Various		1984	1984	7,505		20			7,505	18
19	Various		1985	1985	60,377		20			60,377	19
20	Various		1986	1986	41,792		20			41,792	20
21	Various		1987	1987	17,344	1,156	20	1,156		16,187	21
22	Various		1988	1988	13,840		20			13,824	22
23	Various		1989	1989	10,568		20			10,568	23
24											24
25	PAGE 12-I REPTOTALS				71,506	2,495		2,449	(46)	14,073	25
26											26
27											27
28											28
29	PAGE 12G TOTALS				33,361	924		1,057	133	1,259	29
30	PAGE 12F TOTALS				63,608	2,091		2,225	134	2,225	30
31	PAGE 12E TOTALS				39,578	1,363		1,627	264	2,396	31
32	PAGE 12D TOTALS				64,343	3,851		3,746	(105)	8,101	32
33	PAGE 12C TOTALS				43,201	1,983		2,163	180	6,054	33
34	PAGE 12B TOTALS				50,572	2,661		2,531	(130)	9,528	34
35	PAGE 12A TOTALS				308,681	13,527		13,372	(155)	185,012	35
36	TOTAL (lines 4 thru 35)				\$ 1,166,273	\$ 30,051		\$ 30,326	\$ 275	\$ 718,898	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SHEET & CEMENT			1997	1,324	66	20	66		253	9
10	WALLGUARD & DRYWALL			1997	1,189	59	20	59		231	10
11	NURSES CALL STATIONS			1997	10,320	516	20	516		1,892	11
12	VACUUM PUMP REPAIR			1997	1,314	66	20	66		253	12
13	BATHTUB REFINISHING			1997	530	27	20	27		97	13
14	KLECO-2 WALL PACK FI			1997		114	20		(114)		14
15	SHEET & CEMENT			1997	811	41	20	41		161	15
16	2 LANDINGS SERV GATE			1997	1,500	75	20	75		281	16
17	REPAIR & HTG SYS			1997	1,042	52	20	52		208	17
18	RELOCATE LV WIRING			1997	593	30	20	30		120	18
19	AIR CONDITIONERS			1997	4,215	211	20	211		703	19
20	SPRINKLER REPAIR			1997	1,309	65	20	65		249	20
21	BATHTUB REFINISHING			1997	2,650	133	20	133		488	21
22	REFRIG REPAIR			1997	1,248	62	20	62		207	22
23	CARPETING			1997	1,910	96	20	96		384	23
24	ELEVATOR REPAIR			1997	4,433	222	20	222		851	24
25	KLECO-2 WALL PACK FI			1997	1,144		20	57	57	219	25
26	MINI BLINDS			1997	625	31	20	31		101	26
27	RETRO-FIT FIRE PUMP			1997	1,600	80	20	80		287	27
28	ROOF REPAIR			1997	2,000	100	20	100		350	28
29	TUCKPOINTING			1997	1,600	80	20	80		247	29
30	BOILER REPAIR			1997	2,350	118	20	118		384	30
31	ROOF			1997	3,501	175	20	175		540	31
32	MINI BLINDS			1997	631	32	20	32		112	32
33	INSTALL DOORS			1997	1,000	50	20	50		163	33
34	ELEVATOR RED			1997		160	20		(160)	413	34
35	36 DURAY FIXT			1997	1,733		20	87	87	334	35
36	TOTAL (lines 4 thru 35)				\$ 50,572	\$ 2,661		\$ 2,531	\$ (130)	\$ 9,528	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		KELCO-LIGHTING REAR		1997	993	50	20	50		138	9
10		BATHTUB REFINISHING		1997	530	27	20	27		97	10
11		TILE		1997	957	48	20	48		168	11
12		EXHAUST FANS		1997	2,215		20	111	111	407	12
13											13
14		13 RADIATOR ENCLOSUR		1997	2,518	126	20	126		389	14
15		KELCO-FIRE ALARM REP		1998	1,613	81	20	81		243	15
16		JOHN HARRIS-ROOF REP		1998	5,500	275	20	275		756	16
17		JOHN HARRIS-ROOF REP		1998	1,000	50	20	50		129	17
18		ATASH-SPRINKLER WORK		1998	1,258	63	20	63		168	18
19		JOHN HARRIS-ROOF REP		1998	1,000	50	20	50		133	19
20		J & L - DOORS		1998	4,994	250	20	250		708	20
21		JOHN HARRIS-TUCKPOIN		1998	3,000	150	20	150		325	21
22		JOHN HARRIS-ROOF REP		1998	1,000	50	20	50		125	22
23		RUSH-FIRE DAMPERS		1998	2,547	127	20	127		318	23
24		KELCO-RELOCATE SPRIN		1998	790	40	20	40		110	24
25		HOLLUB-A/C REPAIR		1998	591	30	20	30		80	25
26		KELCO-LIGHTING REPAI		1998	1,120	56	20	56		163	26
27		KELCO-A/C REPAIR		1998	1,060	53	20	53		159	27
28		J & L - METAL DOORS		1998	1,865	93	20	93		256	28
29		F&D HOME IMP-GATE RE		1998	1,025	51	20	51		140	29
30		ELEVATOR DOOR		1998	700		20	35	35	93	30
31		JOHN HARRIS-ROOF REP		1998	900	45	20	45		120	31
32		DOOR		1998	675		20	34	34	102	32
33		F & D -SECURITY BAR		1998	1,000	50	20	50		104	33
34		VERTIDRAPES-BLINDS		1998	3,600	180	20	180		525	34
35		NAT.AWNING-FRONT AWN		1998	750	38	20	38		98	35
36		TOTAL (lines 4 thru 35)			\$ 43,201	\$ 1,983		\$ 2,163	\$ 180	\$ 6,054	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		HOLLEB-BOILER		1998	17,935	897	20	897		2,691	9
10		HOLLUB-A/C REPAIR		1998	973	49	20	49		114	10
11		HOLLUB-BURNER REPAIR		1998	2,345	117	20	117		254	11
12		VERTIDRAPES-BLINDS		1998	1,435	72	20	72		168	12
13		J & L - METAL DOORS		1998	1,268	63	20	63		189	13
14		KOLD MASTERS-THERMOS		1998	2,225	111	20	111		324	14
15		JOHN HARRIS-ROOF		1998	2,800	140	20	140		385	15
16		CRAFTY-CEILING TILES		1998	1,599	80	20	80		187	16
17		ALL ELEVATOR-RECLAIM		1998	5,000	250	20	250		729	17
18		DOORS		1999	675	34	20	34		57	18
19		EMERG.PANEL-GENERATO		1999	4,535	454	20	454		605	19
20		2 DOORS		1999	1,814	91	20	91		121	20
21		ELECTRIC LOCK SYSTEM		1999	1,950	195	20	195		293	21
22		DOOR		1999	2,845	142	20	142		284	22
23		DOORS		1999	660	33	20	33		55	23
24		ROOFTOP A/C UNIT		1999	739	37	20	37		56	24
25		10 MINI BLINDS		1999	620	31	20	31		62	25
26		2 DOORS		1999	1,736	87	20	87		116	26
27		ROOFTOP A/C UNIT		1999	2,465	123	20	123		185	27
28		4 CABINETS		1999	788	39	20	39		59	28
29		2ND FLR SECURITY CAM		1999	1,378	138	20	138		219	29
30		4 VERTICAL BLINDS		1999	1,098	55	20	55		64	30
31		CARPET		1999	1,541	77	20	77		116	31
32		ELECTRICAL WORK		1999		105	20		(105)	201	32
33		CLOSED CIRCUIT SEL		1999	2,688	269	20	269		336	33
34		VERTICAL BLINDS		1999	1,121	56	20	56		107	34
35		PLATED STEEL-ELEVATO		1999	2,110	106	20	106		124	35
36		TOTAL (lines 4 thru 35)			\$ 64,343	\$ 3,851		\$ 3,746	\$ (105)	\$ 8,101	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ELECTRICAL WORK		1999		90	20		(90)	173	9
10		ROOF REPAIR		1999		150	20		(150)	288	10
11		CAPACITOR-ROOFTOP AC		1999	580	29	20	29		41	11
12		ROOF REPAIR		1999	3,607	180	20	180		240	12
13		HARDWARE SUPPLIES-UP		1999	2,622	131	20	131		142	13
14		ROOF REPAIR		1999	2,625	131	20	131		175	14
15		ELEVATOR HYD.PUMP		1999	2,145	107	20	107		143	15
16		WELDING-FEED TANK		1999	1,635	82	20	82		96	16
17		PAINT		1999	1,044	52	20	52		61	17
18		DOOR		1999	1,025	51	20	51		55	18
19		GUTTER REPAIR		1999	1,250	63	20	63		126	19
20		ROOF REPAIR		1999	3,300	165	20	165		220	20
21		ELECTRICAL		2000	1,450		20	55	55	55	21
22		WIRE GLASS	#	2000	650		20	19	19	19	22
23		FAN FOR HEATER	#	2000	750		20	3	3	3	23
24		STEPS	#	2000	6,460		20	162	162	162	24
25		DOOR	#	2000	701		20	9	9	9	25
26		GLASS & CLEAR WIRE	#	2000	505		20	23	23	23	26
27		SPRINKLER HEADS		2000	501		20	25	25	25	27
28		DOORS	#	2000	544		20	20	20	20	28
29		ROOFING		2000	2,500	94	20	94		94	29
30		SPRINKLER HEADS		2000	1,341		20	67	67	67	30
31		SMOKE DETECTORS/CCTV	#	2000	705		20	32	32	32	31
32		PAINT	#	2000	914		20	27	27	27	32
33		WIRING		2000	1,000	38	20	38		38	33
34		BASEMENT DOORS		2000	1,223		20	41	41	41	34
35		DOORS & HINGES		2000	501		20	21	21	21	35
36		TOTAL (lines 4 thru 35)			\$ 39,578	\$ 1,363		\$ 1,627	\$ 264	\$ 2,396	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		IRON ON STEPS		2000	1,365	45	20	45		45	9
10		STEPS DEMOLITION	#	2000	895	26	20	26		26	10
11		REPLACE BRICKS		2000	6,000	250	20	250		250	11
12		ROOFING		2000	5,250	132	20	132		132	12
13		ROOFING		2000	2,500	94	20	94		94	13
14		BLINDS	#	2000	3,356		20	112	112	112	14
15		CONCRETE		2000	3,780	110	20	110		110	15
16		DOOR SWEEP	#	2000	698	18	20	18		18	16
17		PAINT	#	2000	764		20	22	22	22	17
18		DOORS		2000	2,553	128	20	128		128	18
19		GENERATOR		2000	1,832	77	20	77		77	19
20		SPRINKLER	#	2000	875	22	20	22		22	20
21		SPRINKLER	#	2000	1,551	46	20	46		46	21
22		CARPET	#	2000	1,021	47	20	47		47	22
23		DOORS		2000	4,694	137	20	137		137	23
24		PLASTER BOARD		2000	1,501	50	20	50		50	24
25		COMPRESSOR	#	2000	2,125	88	20	88		88	25
26		ELECTRICAL		2000	1,129	56	20	56		56	26
27		SPRINKLER	#	2000	544	18	20	18		18	27
28		PLASTER BOARD		2000	3,247	162	20	162		162	28
29		DOOR SWEEP	#	2000	3,408	57	20	57		57	29
30		DOOR SWEEP	#	2000	701	9	20	9		9	30
31		HOT WATER LINE	#	2000	1,135	52	20	52		52	31
32		SUMP PUMP		2000	2,236	93	20	93		93	32
33		CAFETERIA A/C	#	2000	5,030	126	20	126		126	33
34		WOOD RAILING		2000	4,293	197	20	197		197	34
35		DOORS	#	2000	1,125	51	20	51		51	35
36		TOTAL (lines 4 thru 35)			\$ 63,608	\$ 2,091		\$ 2,225	\$ 134	\$ 2,225	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	STEPS			2000	17,150	591	20	429	(162)	429	9
10	ALARM PANEL			2000	3,800	143	20	143		143	10
11	WALL GUARD			2000	1,853		20	93	93	93	11
12	ALARM SYSTEM			2000	6,500	190	20	190		190	12
13											13
14	# - ADDED AFTER CAPITAL PROJECTION										
15											15
16											16
17											17
18	3RD FLOOR PLUMBING REPAIR			1999	729		20	36	36	72	18
19	3RD FLOOR PLUMBING REPAIR			1999	720		20	36	36	72	19
20	PIPING AND VALVES			1999	609		20	30	30	60	20
21	HEATING/COOLING REPAIRS			1999	2,000		20	100	100	200	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 33,361	\$ 924		\$ 1,057	\$ 133	\$ 1,259	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988	Alloc. Mado	\$ 48,059	\$ 1,748	35	\$ 1,373	\$ (375)	\$ 6,866	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Mado Management			1995	1,115	260	20	56	(204)	307	9
10	Allocation from Mado Management			1993	18,306	487	20	915	428	6,795	10
11	Allocation from Mado Management			2000	4,026		20	105	105	105	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 71,506	\$ 2,495		\$ 2,449	\$ (46)	\$ 14,073	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SACRED HEART HOME, INC.

0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 172,446	\$ 17,130	\$ 14,790	\$ (2,340)		\$ 101,881	37
38	Current Year Purchases	24,723	1,274	1,357	83		1,357	38
39	Fully Depreciated Assets	65,810	395		(395)		65,810	39
40								40
41	TOTALS	\$ 262,979	\$ 18,799	\$ 16,147	\$ (2,652)		\$ 169,048	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	1997 Jeep Cherokee	1998	\$ 24,457	\$ 4,891	\$ 4,891		5	\$ 10,597	42
43										43
44										44
45										45
46	TOTALS			\$ 24,457	\$ 4,891	\$ 4,891			\$ 10,597	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,473,709	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 53,741	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 51,364	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (2,377)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 898,543	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Boiler Repair	\$ 2,297	\$ 115	\$ 345	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 2,297	\$ 115	\$ 345	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SACRED HEART HOME, INC.
0013334
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Sacred Heart	145,753	12,120	12,120		93,823
Mado Management	26,693	5,010	2,670	(2,340)	8,058
TOTALS	172,446	17,130	14,790	(2,340)	101,881

LINE 29: CURRENT YEAR

Sacred Heart	23,113	1,274	1,307	33	1,307
Mado Management	1,610		50	50	50
TOTALS	24,723	1,274	1,357	83	1,357

LINE 30: FULLY DEPRECIATED

Sacred Heart	65,810	395		(395)	65,810
Mado Management					
TOTALS	65,810	395		(395)	65,810

TOTALS (Should Tie to Totals on Page 13)

Sacred Heart	234,676	13,789	13,427	(362)	160,940
Mado Management	28,303	5,010	2,720	(2,290)	8,108
TOTALS	262,979	18,799	16,147	(2,652)	169,048

Facility Name & ID Number SACRED HEART HOME, INC.# 0013334

Report Period Beginning:

01/01/00Ending: 12/31/00**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .9. Option to Buy: ☐ YES ☐ NO Terms: ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES☐ NO16. Rental Amount for movable equipment: \$ 11,357Description: Copier \$2996, Air Cleaner \$3012, Ice Machine \$1119, Vending Machine \$4230

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 0	21

10. Effective dates of current rental agreement:

Beginning Ending 11. Rent to be paid in future years under the current
rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ 13. /2002 \$ 14. /2003 \$ * If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Facility Name & ID Number

SACRED HEART HOME, INC.

#

0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

Special Services - Supplies (Column 6 - Other)	Amount
1 Medical Supplies	
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	
5	
6	
7	
8	
9	
10	

Outside Therapies (Column 5 - Other)		Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 113	\$ 113	1
2	Cash-Patient Deposits	18,634	18,634	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	675,318	675,318	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,497	24,497	6
7	Other Prepaid Expenses	200	200	7
8	Accounts Receivable (owners or related parties)	3,900,245	3,951,309	8
9	Other(specify): See supplemental schedule	5,282	5,282	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,624,289	\$ 4,675,353	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,000	13
14	Buildings, at Historical Cost		140,000	14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	1,210,579	1,225,579	16
17	Accumulated Depreciation (book methods)	(736,316)	(891,316)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 474,263	\$ 494,263	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,098,552	\$ 5,169,616	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 579,050	\$ 599,480	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,534	5,534	28
29	Short-Term Notes Payable	1,125,400		29
30	Accrued Salaries Payable	44,272	44,272	30
31	Accrued Taxes Payable (excluding real estate taxes)	602	602	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,150	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(52)	(52)	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	28,704	28,704	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,783,510	\$ 679,690	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,783,510	\$ 679,690	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,315,042	\$ #REF!	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,098,552	\$ #REF!	48

*(See instructions.)

12/31/00

As of 12/31/00

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses	28,704	28,704

28,704	28,704
--------	--------

OTHER NON CURRENT LIABILITIES:

_____	_____
=====	=====

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,415,651	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,415,651	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(100,609)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (100,609)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,315,042	24

* This must agree with page 17, line 47.

Facility Name & ID Number	SACRED HEART HOME, INC.	#	0013334	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	3,415,651
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Adjustments:

-
-
-

Total adjustments

-

Balance - Beginning of Year

3,415,651

Equity(Deficit) from Page 17 Col 1

3,315,042

Related Party

Equity(Deficit)

Income

991347

183537

1,174,884

Combined Equity - End of Year

4,489,926

Facility Name & ID Number SACRED HEART HOME, INC.

0013334

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,674,194	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,674,194	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	50,705	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 50,705	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	342	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 342	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,725,241	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,275,762	31
32	Health Care	1,125,917	32
33	General Administration	1,046,836	33
	B. Capital Expense		
34	Ownership	248,558	34
	C. Ancillary Expense		
35	Special Cost Centers	18,655	35
36	Provider Participation Fee	110,122	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,825,850	40
41	Income before Income Taxes (line 30 minus line 40)**	(100,609)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (100,609)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? [not complete](#) If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Miscellaneous Income (adjusted out on page 5)	342
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	342

Facility Name & ID Number SACRED HEART HOME, INC.

0013334

Report Period Beginning:

01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	3,068	3,132	50,133	16.01
4	Licensed Practical Nurses	5,825	6,249	75,962	12.16
5	Nurse Aides & Orderlies	40,955	45,827	314,713	6.87
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	11,883	12,885	72,698	5.64
11	Social Service Workers	15,301	16,349	109,562	6.70
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	5,728	6,255	42,173	6.74
15	Cook Helpers/Assistants	17,755	19,695	135,309	6.87
16	Dishwashers	832	1,010	7,849	7.77
17	Maintenance Workers	28,351	30,829	215,929	7.00
18	Housekeepers	24,632	26,790	160,130	5.98
19	Laundry	3,109	3,436	18,771	5.46
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative	312	312	180,000	576.92
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)	0	0	0	33
34	TOTAL (lines 1 - 33)	157,751	172,769	\$ 1,383,229 *	\$ 8.01

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	160	\$ 3,993	1-3
36	Medical Director	8	519	9-3
37	Medical Records Consultant			
38	Nurse Consultant			
39	Pharmacist Consultant			
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant			
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant			
44	Activity Consultant	44	2,310	11-3
45	Social Service Consultant	28	1,470	12-3
46	Other(specify) Dietary Contract Svc.	2,023	28,874	1-3
47	Outside Labor - Activities	Monthly	2,562	11-3
48	Outside Labor - Social Service	6,799	85,543	12-3
49	TOTAL (lines 35 - 48)	9,062	\$ 125,271	

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	9,704	\$ 265,112	10-3
51	Licensed Practical Nurses	5,191	115,670	10-3
52	Nurse Aides			
53	TOTAL (lines 50 - 52)	14,895	\$ 380,782	

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	<u>\$ 0</u>	<u>#DIV/0!</u>

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

Facility Name & ID Number SACRED HEART HOME, INC.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number SACRED HEART HOME, INC.

0013334

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 84 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 94,428
This amount is to be recorded on line 42 of Schedule V _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 36,468 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw